Maryland
DEPARTMENT OF HEALTH
DEVELOPMENTAL DISABILITIES ADMINISTRATION

Person-Centered Plan Development and Authorization

Issued Date: October 1, 2020

Effective Date: October 15, 2020

Contents

Audience

- Individuals and families applying for or current participants of DDA-funded services
- Coordinators of Community Services
- DDA providers
- Developmental Disabilities Administration (DDA) Regional Office (RO) Program and Fiscal Staff

Purpose

This guidance outlines the Developmental Disabilities Administration (DDA) Person-Centered Plan (PCP) development and funding authorization processes. Legacy processes have been updated to:

- Streamline and ensure the PCP is a living document reflecting the participant as a whole throughout the year;
- Support team collaboration, planning, and flexibility for the plan year;
- Decrease the need for Revised PCPs throughout the year;
- Discontinue and eliminate the use of Service Funding Plans and Modified Service Funding Plan (MSFP) processes and forms;
- Increase efficiencies in submitting, reviewing, and approving a PCP;

- Ensure services are properly authorized within the Provider Consumer Information System (PCIS2) until service billing transitions to Maryland's Long-Term Services and Supports (LTSS*Maryland*).

OVERVIEW

As noted by the federal Administration for Community Living (ACL), a Person-Centered Plan (PCP) "helps the person construct and articulate a vision for the future, consider various paths, engage in decision-making and problem solving, monitor progress, and make needed adjustments in a timely manner. It highlights individual responsibility, including taking appropriate risks (for example, whether arranging for back-up staff is needed). Emergency planning is often part of the process." Reference: ACL Person Centered Planning

The DDA's PCP processes include: (1) pre-planning, (2) plan development, (3) plan approval, and (4) plan funding authorization. The entire person-centered planning process lives and is housed in LTSS*Maryland*. **PCP services are authorized for a one year period and must be updated and approved annually.**

Until the DDA system is fully transitioned into LTSS*Maryland*, the DDA will be operating in two systems: LTSS*Maryland* and the legacy Provider Consumer Information System (PCIS2). PCPs will be completed and approved in LTSS*Maryland*, and services will be authorized and billed through PCIS2 until the service provider transitions to LTSS*Maryland*.

As part of the DDA's final transition to LTSS*Maryland*, the DDA issued the "GUIDANCE FOR OPERATING IN PCIS2 AND LTSSMARYLAND", which includes process mapping legacy services to the PCP detailed service authorization request. The DDA has also shared guidance related to the different service names, units, scope, and billing instructions to operate between the two systems.

All participants will follow the same process for requesting services in their PCP. This includes the use of the Detail Service Authorization Tool (DSAT) and Cost Detail Tool being required for all PCPs including for people self-directing their services. The DSAT will help teams identify the appropriate services and units for the LTSS*Maryland* PCP detailed service authorization section and the Cost Detail Tool will be used to assist the Regional Offices with service authorization in PCIS2.

Once the PCP has been completed, the CCS will submit it to the DDA via LTSS*Maryland* for review as per current guidance and policy. Once approved, the DDA will ensure services are documented and authorized in PCIS2. It is important to note that some LTSS*Maryland* services and units do not directly correlate to legacy services authorized in PCIS2. This is due in part to the different rate structures and historical practices of distributing authorized hours among several people residing in the same home. Therefore, teams and DDA staff will need to carefully assess the authorized PCP services to the authorized PCIS2 services to determine if new or additional services or hours are needed or edits are needed to the existing authorization in PCIS2.

Beginning on July 1, 2020, and until the DDA provider's service transitions into LTSS*Maryland*:

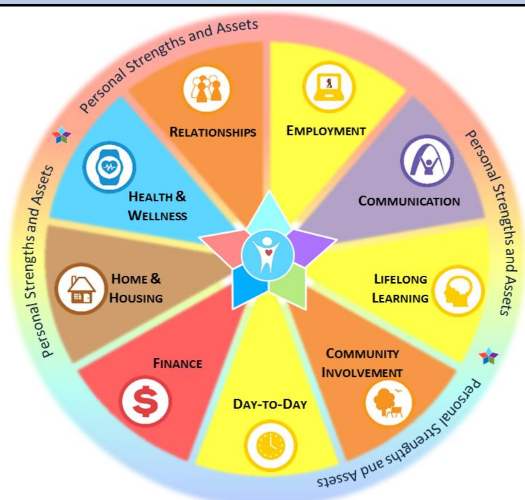
1. Services under the traditional service delivery model will be authorized and billed through PCIS2 with the exception of Personal Support, Supporting living (based on regional EVV go live date), and pilot participants; and
2. Self-directed budgets and services will be authorized through PCIS2 and billed through the FMS.

This guidance focus includes: (1) pre-planning, (2) plan development, (3) plan approval, and (4) plan funding authorization.

APPLICABILITY

This guidance applies to all Initial, Revised, and Annual PCPs for both the self-directed and traditional service delivery models.

PERSON-CENTERED PLAN - PRE-PLANNING



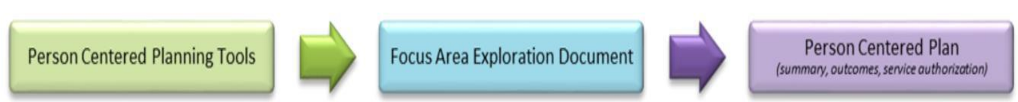
Everyone has the right to live, love, work, play, and pursue their aspirations in their community. Since 2015, the Maryland Developmental Disabilities Administration (DDA) has been wholly transforming our programs, policies and funding processes to put people with developmental disabilities at the center of our efforts.

We place people at the center of planning a vision for their personally-defined good life. This is done through Person-Centered Planning. Our guide for Coordinators of Community Services provides more information on how individuals can choose in “My Life, My Plan, My Choice.”

Comprehensive pre-planning is essential for Initial and Annual Person-Centered Plans (PCPs) to support the participant’s life aspirations and address any unmet needs (i.e. immediate and for the upcoming year) and also reduce the need for a Revised PCP. Pre-planning occurs in collaboration with the participant’s PCP team which includes people chosen by the participant but often includes their family members, friends, and provider agencies.

For Initial, Revised, and Annual PCP’s

1. **Personally-Defined Good Life**
   a. The first and most important part of planning is understanding the participant’s self-defined good life. Before even discussing services and supports, teams need to know and understand what aspirations and goals the participant has in order to assist them with planning.
   b. Before discussing DDA-funded and other services, it is important to understand the participant’s end trajectory so that planning can then begin on the steps to lead self-defined good life.
2. **Person-centered Planning Tools and Strategies**
   a. There are several person-centered planning tools and strategies that may be used in helping each participant to consider their personal strengths, assets, gifts, and wishes across the Life Domains and over the lifespan.
   b. The process involves finding out how each participant prefers to engage. It can be done through a one-to-one conversation; a meeting with family, friends, and/or others important to the participant; a formal process such as the Integrated Star Tool, Essential Lifestyle Planning or PATH; or, most often, a combination of approaches.
   c. Focus Area Exploration (FAE)
      (1) Person-centered planning is a continual process of listening and learning (e.g. exploration and discovery) to create a meaningful and relevant plan that may be adjusted according to life circumstances.
      (2) Discuss focus areas as identified by the participant and included in the PCP as well as outcomes the participant wants to accomplish initially and throughout the PCP year.
      (3) The Employment FAE must be completed annually. All other FAEs are driven by the participant and can be discussed at any time throughout the year, however it is best practice that the team review and complete all FAE’s particularly when there are revisions being made to authorized services. The FAE’s provide a good overview of need and documentation of need for authorized services.



3. **Health Risk Screening Tool (HRST)**
    a. The HRST is used to identify health care needs, risks, and destabilization early. The HRST assigns scores to 22 health and behaviorally related rating items. The total points result in a Health Care Level with an associated degree of health risk. Health Care Levels (HCL) can range from 1 through 6; Level 1 being the lowest risk for health concerns and Level 6 being the highest risk of health concerns. It is important to understand that the HRST measures health risk not disability.
    b. The HRST can help inform teams of health risk that should be considered during planning and also provides recommended staff training.
    c. The HRST should accurately reflect current health needs.
        i. Teams should review the HRST to determine and document risks and mitigation efforts to support those risks in the PCP.
        ii. The HRST must be reviewed, updated, and approved within 90 days of the PCP expiration date.
        iii. The HRST should be completed early on in the PCP pre-planning process to ensure timely submission with the PCP to the regional office.
        iv. The HRST must also be updated when there are major health status changes.

4. **Support Intensity Scale (SIS)**
    a. The SIS measures the participant's support needs in personal, work-related, and social activities in order to identify and describe the types and intensity of the supports a participant may require. It can help provide information and considerations during the person-centered planning processes by the participant and their team.
    b. The SIS is to be completed for all new participants and should be used for development of the Initial PCP.
    c. The DDA has been coordinating with the SIS contractor to conduct a SIS for all other DDA participants. Since the DDA supports over 17,000 individuals, SIS are being completed in phases.
    d. Once completed, the SIS shall be reassessed every five years. The LTSSMaryland system will automatically send a referral to the contractor to complete the SIS and the CCS will also be alerted to the referral.
    e. The CCS shall request completion or ensure a SIS is available for PCP team review and utilization during the pre-planning process.

5. **Assessed Need(s) and Risks**
    a. After the participant's vision has been identified, the PCP team should utilize the HRST and other tools/discussions to assess support need(s), including any that have changed or have not been met and identify health care needs, risks and mitigation strategies.

b. To support an integrated “community life” versus a “service life”, the PCP team should continuously explore generic, natural, community, local, and other resources to meet need(s) and address risk.
    - The Charting the LifeCourse Integrated Star is a useful tool for people, families, and teams to consider an array of integrated supports to achieve the envisioned good life, including those that are publicly or privately funded and based on eligibility, community supports that are available to anyone, relationship based supports technology, and also take into account the assets and strengths of the individual and family. This tool is helpful to get a more comprehensive look at all the services and supports that may exist in a participant’s life; not just eligibility specific supports.

c. After exploration of generic, natural, community, local, and other resources, the PCP team should determine if any remaining unmet support needed can only be met with a Waiver or Medicaid service.

Annual Plan (in addition to the requirements noted above):

1. Preplanning should be initiated within 90 days of PCP Annual Plan date.
2. HRST Reviewers should coordinate or complete the HRST as part of the pre planning process. HRST must be completed within 90 days of the Annual Plan date.
3. Behavioral Plan (as applicable) must be current, (i.e., completed and approved within the last 12 months), reviewed, and updated.

Resources:

Lifecourse Integrated Star link
Maryland Long-Term Services and Supports Person-Centered Plan Overview
PCP CCS Guide
PCP Summary and Outcomes
PCP Focus Area Exploration
DDA PCP Planning web page
DDA HRST web page
DDA SIS web page
Person Centered Planning and Strategies Webinar
Person Centered Plan Authorization Webinar
Supporting Families Community of Practice
Supporting Families Community of Practice - PCP Foundational Tools
Employment Conversations

PERSON-CENTERED PLAN - DEVELOPMENT

Based on information and input gathered through the PCP Pre-Planning process, the next step is the PCP Development process.

1. **The CCS will develop, in collaboration with the participant and their PCP team, a PCP that reflects the:**
    a. Participant's outcomes;
    b. Identified risks, right restrictions, and needs; and
    c. Requested services necessary to ensure the participant is:
        - Healthy
        - Safe
        - Achieving the "good life."

2. **PCP - Outcome Section**
    a. Personal outcomes are goals people set for themself and are defined from the participant's perspective. They are items that each participant identifies as Important To them and standards by which we measure progress and quality of service.
    b. Teams should not only provide needed support, but also help the participant develop natural supports in the community that will assist them in reaching goals.
    c. Outcomes should be associated with each authorized service in the PCP.
    d. Outcomes
        i. As per COMAR Chapter 10.22.01 B. (42) outcomes are tangible results of goals that reflect the desired quality of life as defined by the participant.
        ii. Outcomes are specifically linked to the participant's values and fundamental rights.
        iii. Outcomes can be supported by or in combination of generic, natural, community, local, and other resources in addition to Waiver services.
        iv. The outcome description is a statement to further define what the person wants to happen as a result of the supports, to include person-specific benefit or value. The outcome description related to issues of Importance To the participant should be based on their preferences and should address areas such as relationships of meaning, jobs, or gaining/holding status.
        v. Those outcomes which addressed solely issues of Importance FOR the person addressed either functional/clinical needs, or compliance with a service.
    e. To support an integrated "community life" and prevent a "service life", PCP teams should identify and note:
        (1) How community resources and/or natural support are being used or developed; and
        (2) Natural, community, other contributing resources, and non-DDA funded resources to support the outcome.

3. PCP - Service Authorization Section

a. Requested DDA funded services are noted in the PCP's detailed service authorization section.

b. Requested services should be in accordance with the DDA's Waiver service descriptions taking into consideration:
   (1) Other available resources;
   (2) Assessed unmet need;
   (3) Potential duplication of services; and
   (4) Service scope and limitations.

c. The person-centered planning process in LTSS*Maryland* requires month-by-month service planning. The CCS leads a conversation with the participant and their PCP team to determine which services the participant needs, the amount, and in which months services will be utilized.

d. Detailed Service Authorization Tool (DSAT)
   (1) The DSAT was created to improve and expedite the planning and development process for requested services in the monthly detailed service authorization section.
   (2) The CCS will request the DSAT from Providers, selected by the participant as a guide to help identify the proposed services to meet the participant's needs.
   (3) Providers complete the DSAT, proposing the amount, duration, and scope of services to support the participant to achieve their goals and meet the assessed needs and preferences.
   (4) The provider agency submits the completed DSAT to the participant's CCS, who will review the DSAT with the participant and his or her support team. As always, the participant may accept the proposed services or choose to seek different services that best fit their needs.
   (5) Once the DSAT is submitted to the CCS, the DSA will be uploaded into LTSSMaryland as an attachment to the PCP.
      (a) The form should be saved and uploaded in this standardized format:
         (i) PROVIDERNAME.DSAT.Participant's FIRSTLASTName.DATE (e.g., ABCAgency.DSAT.JonSmith.7-1-2020)
         (ii) The DSAT shall be uploaded in the LTSS*Maryland* PCP documentation section.

Detail Service Authorization Example: In the example on the next page, Behavior Support Services (BSS) are being requested. The BSS-Behavioral Assessment and BSS-Behavioral Plan milestone services are checked each month to support the flexibility in service delivery and the provider's ability to bill in the actual month that the service was provided. Also, 15-minute unit BSS-Brief Support Implementation and BSS-Behavioral Consultation services have units of service across the entire plan year to support the participant's needs and service flexibility.

		Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug			
Existing - 12/04/2019	BSS - Behavioral Assessment		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$1,346.64	Accepted	1/17/2020
Existing - 12/04/2019	BSS - Behavioral Plan		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	$1,346.64	Accepted	1/17/2020
Existing - 12/04/2019	BSS - Behavioral Consultation		40	41	20	22	22	16	18	18	21	40	39	13	$7,908.10	Accepted	1/17/2020
Existing - 12/04/2019	BSS - Brief Support Implementation		22	23	20	9	8	9	9	9	9	8	9	9	$1,536.48	Accepted	1/17/2020

e. PCP - Service Referral

(1) After a DDA-funded service is identified to meet an unmet need and assist the participant in meeting their goal(s), the CCS works with the participant to select a provider for each service.

(2) Upon receipt of the DSAT and Cost Detail Tool from applicable providers, the CCS will indicate the specific provider and site locations (if applicable) in the PCP detailed service authorization section.

(3) LTSS*Maryland* will send a service referral to the provider:

(a) The provider reviews service referrals in the Provider Portal and makes a decision to accept or reject the request.

(b) The provider must take action to accept or reject the referral ***within five (5) days***.

(c) If no action is taken the referral expires and will need to be resent based on the participant's choice.

(d) The CCS should also follow up with the provider to determine if there are technical issues preventing acceptance or if the provider is no longer interested in providing the service.

(e) If the provider is choosing not to accept the referral, the PCP team should work with the participant, and as applicable, designated representative to explore new providers or services to meet assessed needs.

Note: The DSAT will assist with coordination and communication on the service, frequency, and units prior to service referral and can prevent delays in the PCP process.

(4) If either the provider or site that the participant prefers is not available because the provider has not completed enrollment in ePrep or due to a system issue, the CCS shall email the appropriate Regional Office as noted below, who will follow-up with the provider:

- CMRO - Jessica Xander (Jessica.Xander@Maryland.gov)
- SMRO - Teresa Nataline (Teresa.Nataline@Maryland.gov)
- ESRO - Andrea Jones (Andrea.Jones@Maryland.gov)
- WMRO - Timothy Jenkins (Timothy.Jenkins@Maryland.gov)

4. Cost Detail Tool

a. The Cost Detail Tool is used to calculate the cost of services and map LTSS*Maryland* PCP requested services to DDA's legacy services for authorization into the legacy PCIS2.

i. It's important to understand that the cost detail tool is needed for all PCP's (i.e. Initial, Revised, and Annual PCPs) to ensure continued PCIS2 service authorization for applicable services.

ii. This tool is particularly important when there are changes made to authorized services billed in PCIS2.

b. The justification tab

i. The justification tab is required to be completed for any PCP revisions that occur during the annual planning meeting or during the PCP year.

ii. Briefly describe the need or risk resulting in the need for a PCP revision or an Appendix K request. When describing needs steer away from talking about tangible items, rather, what is happening or not happening that a waiver service is essential to ensure health, safety, or community integration. Consider how the need is currently being met, what has changed?

iii. Describe the resources (natural, community, school, DORS, CFC, medical insurance, Medicaid State Plan) the team has exhausted? Why were these resources unable to meet the need?

iv. Describe how these supports will reduce risk; How these services ensure health/safety; and How these services increase community participation.

c. The use of the Cost Detail Tool, in collaboration with an initial, changes made at the Annual, and Revised PCP and the DSAT tool replaces and eliminates the legacy Service Funding Plan and Modified Service Funding Plan Request (MSFPR) processes and forms.

d. For new participants with no service provider selected, the CCS completes the Cost Detail Tool.

e. For participants with selected providers, the provider completes the Cost Detail Tool and submits it to the CCS.
f. For participants using the self-directed service delivery model, the CCS completes the Cost Detail Tool in addition to the self-directed budget.
g. The DDA has developed several resources to assist with service mapping between the two systems including:
    - At a Glance - Meaningful Day Services
    - At a Glance - Support Services
    - At a Glance - Residential Services
    - At a Glance - Personal Supports Services
h. For participants that are (a) currently receiving employment related services from a Meaningful Day provider; AND (b) seeking Employment Services, the Meaningful Day service noted on the approved Cost Detail Tool will be authorized in PCIS2 including Add-ons. Please refer to the DDA Meaningful Day Services Relationship Between LTSS*Maryland* and PCIS2 Services At A Glance for service mapping options.
i. After the CCS reviews and confirms with the participant that the Cost Detail Tool meets their needs and preferences, they upload it in the PCP documentation section so that it is included with the PCP for submission to the Regional Office.
    (1) The form should be saved and uploaded in this standardized format:
        (a) For Cost Detail Tool with *no provider* associated save as: CostDetailTool.Participant'sFIRSTLASTNAME.DATE. (e.g., CostDetailTool.JonSmith.7-1-2020)
        (b) For Cost Detail Tool *with the provider indicated* save as: PROVIDERNAME.CostTool.Participant'sFIRST LASTNAME.DATE (e.g., ABCAgency.CostTool.JonSmith.7-1-2020)
    (2) The Cost Detail Tool shall be uploaded in the LTSS*Maryland* PCP documentation section.

5. Self-Directed Service Delivery Model Budget Determination and Approval

a. Participant's using the self-directed delivery model, annual budget allocations are based on the approved PCP Cost Detail Tool.
b. The Cost Detail Tool includes the current DDA rate for services, including any cost of living increase which are built into each service rate.
c. Once the PCP and associated Cost Detail Tool is approved, the approved services and total cost are then used to create the participant's self-direct budget proposal.
d. Self-Directed Service Delivery Model Budget Approval Criteria and Process:
    (1) The self-directed budget sheet must include the DDA services authorized in the PCP based on the assessed need.
    (2) Participants can determine staffing and pay rates based on the reasonable and customary rate standards.

(3) The self-directed budget sheet for Initial PCP and Annual PCP can not contain allocation of funding for Individual and Family Directed Goods and Services except for Staff Recruitment and Advertising.
(4) The self-directed budget sheet must be submitted and approved by the Regional Office.
(5) Regional Office staff will confirm service included in the self-directed budget matches the assessed services needed in the approved PCP and Cost Detail Tool.
(6) Once approved by the RO, they will send a letter to the Fiscal Management Services agency with the approved budget.

6. PCP - Documentation Section

a. The PCP includes a section for PCP related documents that can be uploaded into the system.
b. Based on the service delivery model chosen by the participant (i.e., self-directed, traditional services delivery model), the documents uploaded may vary.
c. For participants using the self-directed service delivery model, documentation may include self-direction related forms such as the Support Broker Agreement, Self-Directed Budget, Waiver Service Agreement Form, etc.
d. For all participants, the documentation section includes DSATs, Cost Detail Tools, etc.

7. Service Considerations and Flexibility

a. For participants still in school, it is important to consider services needed during times school is not in session, such as winter, spring, and summer breaks.
b. For participants seeking Employment Services including Discovery, Follow Along, Job Development, On-going Job Supports or Self-Employment Development Supports:
   (1) The effective LTSS*Maryland* service billing date can be no earlier than July 1, 2021 unless the participant’s service transitions fully in LTSS*Maryland*.
   (2) Activities that fall under each of these Employment Services (Discovery, Job Development, On-going Job Supports, Follow Along Job Supports and Self Employment Development Supports) can be supported under the appropriate Meaningful Day service based on a participant's individual outcomes and schedule. For instance, it may be common for a participant not yet employed to take part in discovery or job development activities in Community Development Services or Day Habilitation because most of their activities in a given day are non-work related. While a participant receiving supports to maintain their employment would fall under Supported Employment. Please refer to the DDA Meaningful Day Services Relationship Between LTSSMaryland and PCIS2 Services At A Glance for service mapping options.

c. For participants seeking Co-Worker Supports, the effective LTSSMaryland service billing date can be no earlier than July 1, 2021 unless the participant's service transitions fully in LTSSMaryland.

d. To support week-to-week flexibility in participant's employment, schedule, and services needs for Meaningful Day Services, Meaningful Day services can be requested, and authorized by the DDA, up to the weekly limit set forth in the DDA Medicaid Waiver program application, subject to the following limitations.

    (1) Although DDA may authorize up to the weekly limit for each Meaningful Day Service requested,

        (a) Teams should review and discuss service needs including taking into consideration the hours a participant is working (i.e. day time, night time, and weekend hours) and not request the maximum service units for each Meaningful Day service;

        (b) Participants cannot receive and provider will not be paid for more than the limit for Meaningful Day services set forth in the DDA Medicaid Waiver program application - a total of 40 hours per week for all authorized Meaningful Day services combined.

    (2) Neither a service provider nor a participant through a Fiscal Management Services provider may submit a claim for payment to DDA for Meaningful Day Services provided in excess of the weekly limit. Such a claim for payment will be denied.

    (3) For example, a participant may be authorized to receive Community Development Services, Employment Services, and other Meaningful Day Services. For maximum flexibility, the DDA can approve up to 40 hours per week of combination of each of these services. However, in combination, the participant may not use, and the provider may not bill for, more than a total of 40 hours of Meaningful Day services within a week.

        (a) Week One: The participant may receive 10 hours of Community Development Services and 30 hours of Employment Services.

        (b) Week Two: The participant may receive 20 hours of Community Development Services and 20 hours of Employment Services.

        (c) The participant may not receive 40 hours of Community Development Services and 40 hours of Employment Services in a single week.

e. For Behavioral Consultation services, it is important to consider potential monthly consultation units needed in addition to scheduled reviews, in the case of an emergency or off cycle review.

f. For participants seeking Community-Living - Enhanced Supports, the effective LTSSMaryland service billing date can be no earlier than July 1, 2021 unless the participant's service transitions fully in LTSSMaryland. Until the transition, participants in need of residential services should request Community Living - Group Home services which will be authorized as Residential in PCIS2.

g. Milestone units are indicated with a check mark in the detail service authorization section. To support flexibility in the receipt of these services, each month can be checked as shown below.

Service Status & Effective Date	Service and Provider	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug

✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓ ✓

h. Residential Services: Dedicated Hours - For participants in need of dedicated support hours for residential services, the following should be considered before requesting.

(1) The PCP includes Community Living-Group Home, Community Living - Enhanced Supports, and Supported Living and Dedicated Hours as residential service options.

(a) Dedicated Hours are hours that provide 1:1 or 2:1 participant to staff ratio based on the assessed need for habilitation and community integration. They are reflected in LTSS*Maryland* as follows:

1) Dedicated Hours for Community Living - Group Home (1:1)
2) Dedicated Hours for Community Living - Group Home (2:1)
3) Dedicated Hours for Community Living - Enhanced Supports (1:1)
4) Dedicated Hours for Community Living - Enhanced Supports (2:1)
5) Dedicated Hours for Supported Living (1:1)
6) Dedicated Hours for Supported Living (2:1)

(b) If the participant's needs cannot be met through residential services base services hours or overnight supports (as applicable based on the provider's business model), then a request for dedicated staff hours may be requested.

1) The person-centered planning process should include a discussion of the participant's support needs, number of hours available in the home, and the availability of overnight support.
2) Provider's assessed need for dedicated hours will be based on:
   a) participant's assessed need (i.e. medical, behavioral, community);
   b) Number of people in the home supported by shared hours;
   c) Provider's business model (i.e. overnight support staff vs no overnight support staff) and
   d) Provider staffing model (e.g., use overnight support staff vs hiring dedicated staff)

3) Based on these considerations, a request for dedicated supports for any additional hours that the participant will need can be made.

(c) Participants with an assessed need for additional supports can request Dedicated Hours in addition to the main residential service (i.e. Community Living-Group Home, Community Living - Enhanced Supports, and Supported Living). If approved, the participant will have both the main service and the dedicated service listed in the detail service authorization section.

(d) Dedicated 1:1 hours cannot be authorized when the house reaches 1:1 support for each participant living in the home.

(e) Dedicated hours are not limited to services provided inside the home and can support the participant with community engagement.

i. Meaningful Day Services: 1:1 and 2:1 Staffing

(1) If the participant's needs cannot be met by the Day Habilitation Small or Large Group services or Community Development Services (2- 4 participant groups) then a request can be made for Community Development Services 1:1 / 2:1 staffing ratio or Day Habilitation 1:1 / 2:1 staffing ratio.

(a) The person-centered planning process should include a discussion of the participant's support needs, level of supports, and hours needed.

(b) Based on these considerations, a request for 1:1 / 2:1 staffing ratio hours that the participant will need can be made.

(c) The detail service authorization can reflect both (1) the group services (i.e. Day Habilitation Small, Large Group, or Community Development Services (2- 4 participant groups); and (2) Community Development Services 1:1 / 2:1 or Day Habilitation 1:1 / 2:1 staffing ratios.

(d) LTSS*Maryland* functionality is being enhanced to support billing of various Day Habilitation and Community Development Services support models (e.g., small group, 1:2, etc.) during the same day.

(e) Career Exploration 1:1 / 2:1 Staffing Ratio funding is not available.

(2) Some Meaningful Day 1:1 and 2:1 staffing hours service authorization can be directly mapped between LTSS*Maryland* 1:1 and 2:1 staffing ratio to PCIS2 1:1 and 2:1 add-on hours. However there are a few differences for some services and how the rates are constructed.

(a) Services authorized in LTSS*Maryland* detail service authorization section include rates for:

1) Community Development Services 1:1 Staffing Ratio;
2) Community Development Services 2:1 Staffing Ratio;
3) Day Habilitation 1:1 Staffing Ratio; and
4) Day Habilitation 2:1 Staffing Ratio.

(b) Services authorized in PCIS2 include:

1) 1:1 and 2:1 add-ons hours can be included in the FY21 Cost Detail Tool and authorized in PCIS2 for Meaningful Day Services when a participant needs more staffing support than what is included in the rate for the participant's matrix;
2) Add-ons can be associated with Supported Employment, Employment Discovery & Customization, Career Exploration, Community Development Services, and Day Habilitation;
3) Rates based upon the participant's matrix scores;
4) In PCIS2, 1:1 and 2:1 add-on hours are incorporated into Meaningful Day Service main service and billed as one rate.

j. Meaningful Day Services: Transportation Add On

(1) Providers in need of the Meaningful Day Transportation Add On shall include it in their Cost Detail Tool. It does not need to be noted in the LTSS*Maryland* PCP detailed service authorization.

(2) Once the Cost Detail Tool is approved, the Transportation Add On will be authorized in PCIS2.

(3) Once the Meaningful Day Service is transitioned to LTSS*Maryland,* the Meaningful Day Transportation Add On will be ended as the rate includes a transportation cost component within it.

Resources

DDA Waivers web page

DDA Waiver Programs Webinar

DDA Service Authorization Guidelines

PCP Review Checklist

Operating in PCIS2 and LTSS Guidance

Guidelines for Detailed Service Authorizations and Provider Billing Documentation

Link to Cost Detail Tool

Link to the SDS Budget sheet

Link to the Waiver Services Agreement Form (SDS Only)

Link to Support Broker Structured Interview Checklist

Support Broker Agreement form

Family as Staff form

PERSON-CENTERED PLAN - APPROVAL

The PCP Approval process includes: (1) the service referral acceptance from the provider; (2) the participants or their legally authorized representatives approval; (3) the CCS approval; and (4) the final approval by the DDA.

Provider Approval - Service Referral Acceptance

1. The Providers acceptance of the PCP service referral is their approval.
2. When the provider accepts the service referral, the system will general and save the "Provider Signature Page" in the PCP "Signature" Section.

Participants or their Legally Authorized Representatives Approval

1. The CCS will review the draft PCP, providers proposed service(s), scope, and frequency with the participant and their legally authorized representatives (if applicable) to see if the PCP clearly outlines their vision, goals, and supports (including natural, community, and State funded supports).
2. If approved by the participant, the CCS facilitates the participants agreement on the "Participant Signature Page" and uploads in the PCP "Signature" Section.
3. If approved by the legally authorized representative, agreement on the "Authorized Representative Signature Page" and uploads in the PCP "Signature" Section.
4. If not approved, the CCS facilitates further discussions with the team until agreement or changes to the plan are made including selecting different services or providers.

Coordinators of Community Services Approval

1. The CCS indicates their agreement to the PCP by completing the "Coordinators of Community Services (CCS) Signature Page" and uploading in the PCP "Signature" Section.
2. Prior to approving the PCP, the CCS should complete a final review of the PCP to ensure it meets all DDA requirements. The PCP Review Checklist is a good tool that can be used for review of the PCP. Once finalized they submit, via LTSS*Maryland*, to the Regional Office.
    a. *Annual plans must be submitted no later than 20 business days prior to the PCP annual plan date.*
    b. Initial and revised plans should be submitted within ten business days or less after the participants or their legally authorized representatives approval.

Regional Office Program Team

The DDA Regional Office approval of the PCP is noted in the PCP "Service Plan Workflow History" Section.

1. Regional Offices receive, review, request consults, request clarifications, and approve Initial, Annual, or Revised PCP through LTSS*Maryland.*
2. Regional Office Program Team staff will:
    a. Review PCPs within 20 business days of receipt;
    b. Review PCP using the PCP Review Checklist
    c. Assess needs based on DDA Service Authorization guidelines. Authorized services are based on an assessed need and the DDA Medicaid Waiver program's service requirements as noted in the approved Medicaid Waiver program applications;
    d. Verify that, for plans submitted after September 21, 2020, the DSAT has been completed and uploaded unless otherwise directed. Plans for which the DSAT has not been uploaded will be returned to the CCS for resubmission after the DSAT is attached.
    e. Review the correlation between the LTSS*Maryland* Detailed Service Authorization request to applicable PCIS2 authorizations *(unless pilot participant)*
        (1) Dedicated hours vs Add-On hours
            (a) For participants currently in Residential (Community Living - Group Home) and Supported Living services, the Regional Office program staff will assess the PCP approved services and Cost Detail Tool with the current authorization in PCIS2.
                1) If there is no change in needs, the add-on hours should remain the same.
                2) If there is an increase/decrease in needs, the add-on hours should be increased/decreased.
        (2) For participants with a change in either services or needs, staff will assess if there is a documented assessed need that indicates a variance in current staffing supports from what is already included through the Matrix score or PCIS2 authorization.
        (3) For participants new to service, the following should be considered:
            (a) Does the participant require overnight staffing? If so, are shared hours sufficient to meet the participant's needs?
                1) If the house does not already have shared hours, or they are insufficient, or the participant needs one-to-one supports should be reassessed.
                2) If home share hours are sufficient, then additional hours should not be authorized.
            (b) Are there already shared hours in the home, or do these need to be added?
                1) If yes then add or increase to add on hours.

2) If no, then make no changes to the current PCIS2 authorization.

(c) In addition to overnight supports, is there a documented assessed need that indicates a variance in staffing supports from what is already included through the Matrix score or authorized in PCIS2?

1) If yes then add or increase to add on hours.
2) If no, then make no changes to the current PCIS2 authorization.

f. Review Cost Detail Tool to ensure:
(1) Correlation between requested services and correct PCIS2 rates;
(2) Matrix score and award number are accurate;
(3) No duplication of services;
(4) The agency chosen is licensed and certified to provide authorized services;
(5) An accurate start date of services is reflected;

g. If applicable, review the Self-Directed Service Budget sheet to ensure:
(1) Aligns with services authorized in the LTSS*Maryland* Detailed Service Authorization; and
(2) Utilizes rates in accordance with the reasonable and customary rate standards.

h. Confirm an outcome is associated for every DDA funded service requested.

i. If a request is for a site change:
(1) Check PCIS2 to ensure capacity will not be exceeded; and
(2) Collaborate with Provider Relations/Quality Enhancement staff for Residential Site Configuration changes as applicable.

j. If clarification is needed, the PCP will be sent back to CCS via LTSS*Maryland* clarification request functionality.

k. If internal consultation is needed for behavior support services, nursing, or program related questions, send “CONSULT to applicable staff via LTSSMaryland functionality.

l. If clarification is not necessary and PCP meets criteria for APPROVAL, RO Program Staff will then finalize approval in LTSS*Maryland* and if there was a change to authorized services (new or revised) specific to those in PCIS2 send the Cost Detail Tool to the RO fiscal staff)for entry into PCIS2 and processing.

m. For all Annual and Revised PCPs (either at annual PCP meeting or through mid year PCP revision) that meet the DDA Regional Director PCP Revision Review Criteria, the Program Staff will send a “CONSULT to Regional Director/Deputy via LTSS*Maryland* functionality.

n. If an assessed need is not demonstrated or clarification returned still does not document a substantiated need:
(1) For Initial and Annual PCPs, deny the plan;

    (2) For Revised PCP, deny only if it is a mid plan year revised PCP, otherwise consult with program team supervisor for next steps;
    (3) Create a LTSSMaryland denial letter which include appeal rights; and
    (4) Forward to regional admin team for processing.
o. If PCP does not meet DDA Regional Director PCP Review Criteria and all PCP criteria is met, the RO Program staff will then finalize approval in LTSS*Maryland* and if there was a change to authorized services (new or revised) specific to those in PCIS2 send the Cost Detail Tool to the RO fiscal staff for entry into PCIS2 for processing.

DDA Regional Director PCP Review

1. As applicable, Program Staff will send a PCP CONSULT to the Deputy/Regional Director for review if the PCPmeets the DDA Regional Director PCP Review Criteria as follows:
    a. Total Plan Cost:
        (1) Residential services plan cost of $175,000 or more;
        (2) Personal Supports plan cost of $150,000 or more;
    b. Authorization Threshold:
        (1) Assistive Technology cost over $1,000;
        (2) Employment Discovery request more than one time during a 24-month period;
        (3) Job Development service request from another provider;
        (4) 2:1 service request;
        (5) More than one Behavioral Assessment or Behavior Plan in a 12 month period;
        (6) Environmental Modification over $2,000;
        (7) All service requests that exceed the Waiver service cost limits; and
    c. Random 10% sample pull of submitted changes made to an Annual or an Revised PCPs each month.
2. Upon receipt of the LTSS*Maryland* CONSULT from RO Program Staff based on revision review criteria outlined above,, the Deputy/Regional Director will authorize continuation of the PCP review and determination process by RO program staff based on service authorization guidelines.

Resources

PCP Review Checklist

PCP Service Authorization Guidance

PERSON-CENTERED PLAN - AUTHORIZATION

A. LTSS*Maryland* Pilot Providers

On December 1, 2019, the DDA began a pilot program to test the service authorization and billing functions of the LTSS*Maryland* system. The pilot program tests billing functionality, identifies and resolves system issues, and helps the DDA learn about the operational and training needs of providers so they can successfully use the new system.

1. If the provider and participant are participating in the fee-for-service pilot program, the PCP Approval is the funding authorization and no further action is needed.
2. These providers and participants will follow applicable guidance for the fee-for-service pilot program.

B. Early Adopters

To provide more time to test and make adjustments to the LTSS*Maryland* system and to ensure fiscal payment strategies function properly, the DDA will expand the pilot program. New providers who volunteered to test the system are referred to as “early-adopters”. These providers' services and sites will be activated in LTSS*Maryland* to support billing functionality.

1. The provider’s LTSS*Maryland* services billing date will be set for the first of the agreed implementation month.
2. DDA Headquarter staff will end services in PCIS2 15-days after the transition date to provide a buffer.
3. The LTSS*Maryland* PCP Approval is the funding authorization and no authorization is needed in PCIS2.
4. These providers and participants will follow applicable guidance for the fee-for-service pilot program.

C. All Others Providers

1. For providers and participants not participating in the fee-for-service pilot program, final authorization of services (and their approved scope, frequency, duration, and rates) by both the provider and the DDA will occur only in PCIS2.

   Important Note:
   For providers and participants not participating in the fee-for-service pilot program, final authorization of services (and their approved scope, frequency, duration, and rates) by both the provider and the DDA will occur only in PCIS2. To cross-walk between LTSS*Maryland* and PCIS2, the provider (or CCS for participants enrolled in self-directed services) must review the requested services

in the PCP in LTSS*Maryland* and then complete a Cost Detail Tool to apply the rates from PCIS2. If PCIS2 rates apply, then any services authorization by the provider or the DDA in LTSS*Maryland* will not have any final legal effect, unless the provider and participant are participating in the fee-for-service pilot program.

2. RO Review and Authorization Processes

a. Fiscal Staff
   (1) Review Cost Detail Tool if there was a new or revised service authorized in the PCP that is billed in PCIS2.
      (a) Enter authorized services into PCIS2; OR
      (b) Forward back to program team supervisor if there are errors that prevent entry into PCIS2
   (2) Once entered into PCIS2, fiscal staff will create a PDF that includes:
      (a) Cost Detail Tool or SDS budget sheet; and
      (b) Copy of the PCP Revision approval letter from LTSS*Maryland*
   (3) Send completed PDF to RO Fiscal Director /Designee designated email for signatures.

b. RO Fiscal Director/Designee
   (1) Receive and review fiscal PDF for accuracy and quality;
   (2) As applicable, forward fiscal PDF to Deputy/Regional Director for final signature if the revision meets the DDA Regional Director PCP Review Criteria;
   (3) If fiscal PDF does not require Regional Director approval, sign off on PDF and send to admin staff for processing;
   (4) If errors are identified, they send the fiscal PDF back to applicable fiscal staff for review, correction, and resubmission.

c. Regional Director or Designee
   For PCPs that meet the DDA Regional Director PCP Review Criteria:
   (1) Reviews fiscal PDF to ensure accuracy and quality.
   (2) If approved, sign off on fiscal PDF and send via email to admin staff.
   (3) If not approved, send back to fiscal and/or program directors for review, correction, and resubmission.

d. DDA RO Admin Staff
   (1) Receive approved fiscal PDF from Regional Director or designee;
   (2) Log completion of fiscal PDF on RO tracker/ spreadsheet and save per regional saving conventions;
   (3) Send approval/denial letters with appeal rights (for denials) to individual;
   (4) Scan or upload signed fiscal packet to regionally designated location;
   (5) Email packet to applicable provider, CCS, and individual; and

(6) As applicable, for participant's self-directing services, send the PCP, approved self-directed budget sheet, signed Waiver Services Agreement form to the Fiscal Management Services provider.